

Entering a CA-1 On-line

Introduction

Submitting a claim electronically consists of two actions...

1. Initial entry of the claim information by the supervisor and the employee
2. Injury Compensation Program Administrator (ICPA) reviews the claim and submits the claim to the Office of Worker's Compensation Program (OWCP)

This presentation will focus on the first action.

Objectives

Upon completion you will be able to:

1. Access the supervisor portion of the EDI application
2. Enter information into a CA-1 form
3. Submit the form to the ICPA

Accessing the EDI Application

The easiest way to access the EDI Application is through the [DCPAS ICUC Web page](#).

Select **File Claims Online**
(Supervisor's Link)

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Injury and Unemployment Compensation (ICUC) Branch

Managing your civilian Injury Compensation and Unemployment Compensation (ICUC) programs can be a challenge to your HR organization. The ICUC Branch, a part of the HR Operational Programs and Advisory Services, Benefits and Work Life Programs Division, has expert advisors who will provide proven online training, support and solutions to help reduce your compensation costs and meet your HR requirements.

In addition, the ICUC Branch will assist all DOD agencies with advice and guidance regarding the Privacy Act to ensure confidentiality is maintained. ICUC is available to assist in facilitating your electronic communication and personally identifiable information challenges to ensure that the User Access Guidelines are met. Contact us to find out what we can do for your organization.

ICUC NAVIGATION

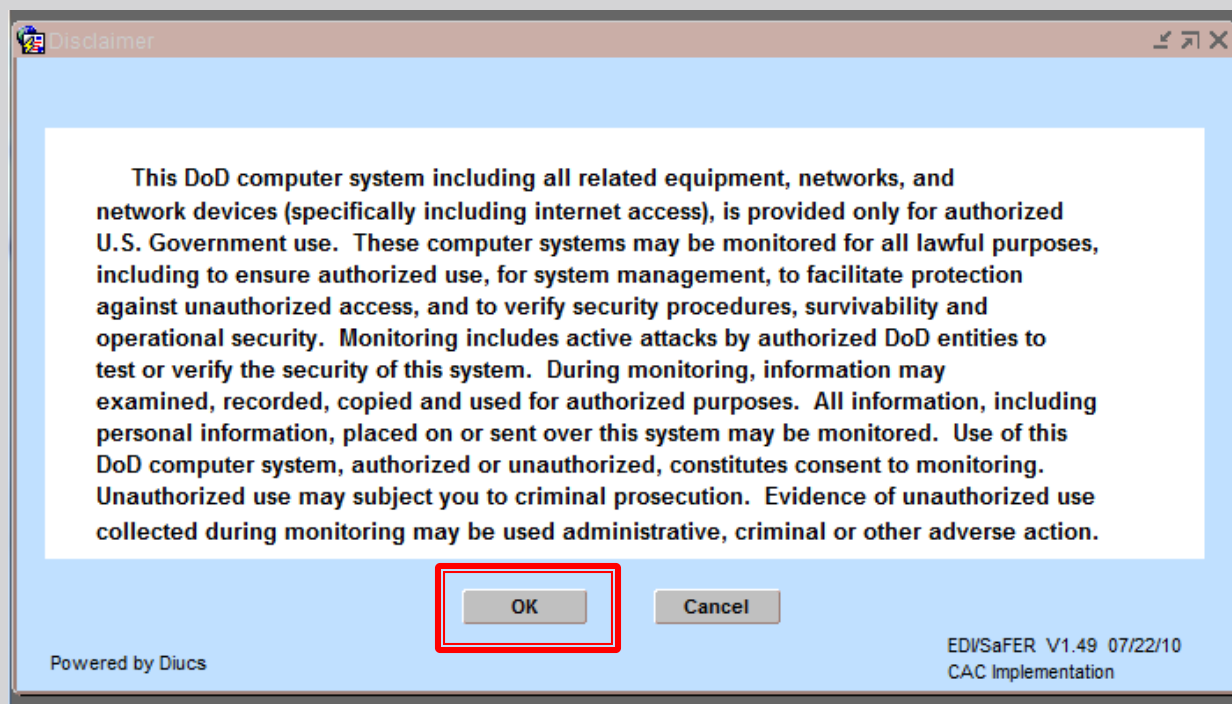
- Injury Compensation
- Unemployment Compensation
- Pipeline
- Training Opportunities
- Online Tools

PRODUCTS & SERVICES

- File Claims Online (Supervisor's Link)**
- Access DIUCS
- Access Distance Learning Program
- Access OWCP AOS (Agency Query System)
- Access OWCP COS (Claimant Query System)
- Request ICUC System Access
- Request Password Reset
- Modify ICUC Systems Access
- Learn About DOD Overseas Civilian Opportunities

Injury	Unemployment	Pipeline	Training	Online Tools
Overview	Requirements (FECA)	Injury Compensation Support Services		
Workplace injuries can happen anywhere, anytime—placing an immediate administrative burden on supervisors and impacting short-term and possibly long-term productivity.	The Federal Employees' Compensation Act (FECA), 5 USC 8101et seq., provides compensation benefits to Federal civilian employees for work-related injuries or illnesses.	ICUC provides formal liaison services to help open communications and foster a strong working relationship between DOD and the OWCP office.		
What to Do If You Are Injured	How to File a Claim	Responsibilities of Supervisors		
If you are injured at work, you may be entitled to injury	When injured, your supervisor must be notified as soon as possible that	When a civilian employee is injured as a result of work.		

When the EDI application starts, a security notification screen will open. Select **OK** in order to access the application.



Once the initial claim screen appears, the SSN and Date of Birth (DOB) are entered as well as the type of claim being filed Traumatic injury (CA-1) or Occupational Disease/Illness (CA-2)

The screenshot shows a software window titled "Supervisor Entry" with a standard Windows-style title bar. The main content area has a light blue background and contains the following elements:

- Header:** "Enter A New U.S. Department of Labor" followed by "Worker's Compensation Claim Form:" in bold.
- Claimant Section:** A rounded rectangular box containing two input fields:
 - "Social Security Number (SSN):" followed by a text input field.
 - "Date of Birth (MM/DD/YYYY):" followed by a text input field.
- Claim Form Type Section:** A rounded rectangular box containing two radio button options:
 - ☒ CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
 - ☐ CA-2 Notice of Occupational Disease and Claim for Compensation
- Buttons:** Two blue buttons with white text: "Enter claim" on the left and "Exit" on the right.
- Footer:** The text "Powered by Diucs" is located at the bottom left of the window.

The EDI application then checks information from the Personnel database (DCPDS) using the SSN and DOB to verify that the individual is an employee.

If the SSN or DOB do match any record in the database, the system will generate an error message.

You will not be able to file electronically.

Contact your ICPA if you receive this error message.

If the SSN and DOB match a record then the claim form will open.

The screenshot shows a web application window titled "Supervisor Entry". The main heading is "Enter A New U.S. Department of Labor Worker's Compensation Claim Form:". Below this, there are two sections: "Claimant" and "Claim Form Type". In the "Claimant" section, the "Social Security Number (SSN)" field contains "111-11-1111" and the "Date of Birth (MM/DD/YYYY)" field is empty. In the "Claim Form Type" section, there are two radio buttons: "CA-1 Federal Employee's N" (selected) and "CA-2 Notice of Occupation". At the bottom of the form, there are two buttons: "Enter claim" and "Exit". A yellow error message box is overlaid on the form, stating "Claim cannot be submitted electronically!" and "Information on claimant (SSN: 111111111 DOB: 02/01/1960) is currently unavailable. You cannot file the claim electronically at this time. Contact your ICPA for guidance on filing this claim." The error box has a yellow warning icon and two buttons: "Re-enter SSN and DOB" and "Exit". The footer of the application says "Powered by Diucs".

Supervisor Entry

**Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:**

Claimant

Social Security Number (SSN): 111-11-1111

Date of Birth (MM/DD/YYYY)

Claim Form Type

☒ CA-1 Federal Employee's N

☐ CA-2 Notice of Occupation

Claim cannot be submitted electronically!

Information on claimant (SSN: 111111111 DOB: 02/01/1960) is currently unavailable. You cannot file the claim electronically at this time. Contact your ICPA for guidance on filing this claim.

Re-enter SSN and DOB Exit

Enter claim Exit

Powered by Diucs

The claim form will then open.

1 Certain claimant information will be filled in by the EDI application using information from DCPDS (Personnel) system.

1

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee
Last Name: OUTLAND, First Name: ASHLEY
Middle Name: C, Suffix: (not entered)

2. Social Security Number
327-84-4988

3. Date of birth
MM-DD-YYYY
04-30-1984

4. Sex
☐ Male ☒ Female

5. Home Phone
6026294818

6. Grade as of date of injury
Level: GS09 Step: 03

7. Employee's home mailing address
Street Address: 1335 N 52ND STREET BLDG 5710
City: PHOENIX
State: AZ ZIP Code: 85008

8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ Other

Claim information
EDI claim number: Status:
Trading partner ID: FECAEDI Status time:

Powered by Diucs

View Claim Submit Claim Cancel Exit

The fields are color coded.

Each color signifies whether the data is;

1. required (white),
2. optional (yellow) or
3. for information only (gray).

The screenshot shows a web-based form titled "EDI_CA1" with a tabbed interface. The tabs include "Emp. Data", "Injury", "Emp. Signature", "Witness", "Sup Rpt 1", "Sup Rpt 2", "Sup Rpt 3", "Sup Rpt 4", "Safety Data", and "Sup Signature". The "Emp. Data" tab is active. The form is divided into several sections, each with a numbered header. The fields are color-coded: white for required, yellow for optional, and gray for information only. Red boxes with numbers 1, 2, and 3 are placed over the form, with arrows pointing to specific fields. Box 1 points to the "Sup Rpt 1" tab. Box 2 points to the "Middle Name" field. Box 3 points to the "EDI claim number" field.

1. Name of employee
Last Name: OUTLAND, First Name: ASHLEY
Middle Name: C, Suffix: (not entered)

2. Social Security Number
327-84-4988

3. Date of birth
MM-DD-YYYY
04-30-1984

4. Sex
☐ Male ☒ Female

5. Home Phone
6026294818

6. Grade as of date of injury
Level: GS09 Step: 03

7. Employee's home mailing address
Street Address: 1335 N 52ND STREET BLDG 5710
City: PHOENIX
State: AZ ZIP Code: 85008

8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ Other

Claim information
EDI claim number: [gray field] Status: [gray field]
Trading partner ID: FECAEDI Status time: [gray field]

Powered by Diucs

View Claim Submit Claim Cancel Exit

For the required information to be entered using a particular format. If the data entered is in an improper format, the application will not allow any further progress until the information is input in the proper format.

A message will display on the status bar at the bottom left of the screen alerting the user to the error and the proper format.

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee
Last Name: OUTLAND, First Name: ASHLEY
Middle Name: C, Suffix: (not entered)

2. Social Security Number
327-84-4988

3. Date of birth
MM-DD-YYYY
04-30-1984

4. Sex
☐ Male ☒ Female

5. Home Phone
602-629-4818

6. Grade as of date of injury
Level: GS09 Step: 03

7. Employee's home mailing address
Street Address: 1335 N 52ND STREET BLDG 5710
City: PHOENIX
State: AZ ZIP Code: 85008

8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ Other

Claim information
EDI claim number: Status:
Trading partner ID: FECAEDI Status time:

Powered by Diucs

View Claim Submit Claim Cancel Exit

FRM-40209: Field must be of form FM9999999999999999.
Record: 1/1

The application contains certain features that make it easier to enter information into the form.

Certain fields will display a searchable list of available values for that particular field.

A message on the status bar will let you know that if the **CTRL+L** function is available for that field.

The screenshot shows a software application window titled "EDI_CA1". The window has a menu bar with the following options: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2, Sup Rpt 3, Sup Rpt 4, Safety Data, and Sup Signature. The main form area is divided into several sections:

- 1. Name of employee:** Includes fields for Last Name (OUTLAND), First Name (ASHLEY), Middle Name (C), and Suffix (not entered).
- 2. Social Security Number:** Field containing 327-84-4988.
- 3. Date of birth:** Field containing 04-30-1984.
- 4. Sex:** Radio buttons for Male and Female.
- 5. Home Phone:** Field containing 6026294818.
- 6. Grade as of date of injury:** Fields for Level (GS09) and Step (03).
- 7. Employee's home mailing address:** Includes fields for Street Address (1335 N 52ND STREET BLDG 5710), City (PHOENIX), State (AZ), and ZIP Code (85008).
- 8. Dependents:** Checkboxes for Wife, Husband; Children under 18 years; and Other.
- Claim information:** Fields for EDI claim number, Status, Trading partner ID (FECAEDI), and Status time.

At the bottom of the form, it says "Powered by Diucs". Below the form are four buttons: View Claim, Submit Claim, Cancel, and Exit.

A status bar at the bottom of the window displays the message: "Display List of Corresponding Zip Codes - Press CTRL+L." and "Record: 1/1".

Employee's Data Tab

By using **CTRL+L** key combination while the cursor is in the field will open a dialog box that will allow you to search and select a value for the field.

Enter the city name next to the **%** and click the **Find** button and the list of zip codes for that city will appear. Scroll until you locate the correct zip, select, then click **OK**.

The screenshot displays the 'EDI_CA1' application window with the 'Employee's Data' tab selected. The form contains several sections for data entry:

- 1. Name of employee:** Last Name: OUTLAND, First Name: ASHLEY, Middle Name: C, Suffix: (not entered), Social Security Number: 327-84-4988.
- 3. Date of birth:** 04-30-1984.
- 4. Sex:** Male (selected), Female.
- 5. Home Phone:** 6026294818.
- 6. Grade as of date of injury:** Level: GS09, Step: 03.
- 7. Employee's home mailing address:** Street Address: 1335 N 52ND STREET BLDG 5710, City: PHOENIX, State: AZ, ZIP Code: 85008.
- 8. Dependents:** Wife, Husband (unchecked), Children under 18 years (unchecked), Other (unchecked).
- Claim information:** EDI claim number, Status, Trading partner ID: FECAEDI, Status time.

At the bottom, there are 'View Claim' and 'Submit Claim' buttons. Two 'Listing of Zip Codes' dialog boxes are overlaid on the main form:

- The top dialog box shows a search for 'AZ%' and a list of zip codes for various cities in Arizona, including CATALINA, TUCSON, SADDLEBROOKE, ORO VALLEY, and TUCSON.
- The bottom dialog box shows a search for 'AZ%Phoenix' and a list of zip codes for Phoenix, ranging from 85001 to 85007.

Injury Tab

The **employee** will enter information into the white fields of the claim form.

Block 9 Place where injury occurred: Enter the Work Location Address where the injury occurred. *It should be the mailing address of the location rather than just a building or work center name.*

Block 10 Date & time injury occurred: Enter the date and time injury. If no time is entered then the application will enter a default time of 12:00AM. DO NOT enter time in a military format (i.e. 1700 hrs).

Block 11 Date of this notice: This field should contain the date the claim is being entered into the EDI application or the date the employee signed the paper copy of the CA-1 form.

Block 12 Employee's Occupation Description: Will automatically fill by the application based on what is in the personnel system. However, if the information is incorrect it can be changed.

Block 13 Cause of Injury: Enter the cause of the injury. Be as specific as possible. Tell how much the object weighed, how did the employee fall and from what height, what task was being performed when injured. The information provided should always be in 1st person.

Block 14 Nature of Injury: Enter the nature of injury. Identify the injury and specific body part and/or area of injury such as sprained left knee, strained right shoulder, laceration to left middle finger, etc.

The image displays two screenshots of the EDI_CA1 form, specifically the 'Injury' tab. The top screenshot shows the form with most fields empty, while the bottom screenshot shows the form filled out with example data.

Top Screenshot (Empty Form):

- 9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine):** Empty text field.
- 10. Date & time injury occurred MM-DD-YYYY HH:MM [AM/PM]:** 12-10-2013 12:00 AM
- 11. Date of this notice MM-DD-YYYY:** 12-10-2013
- 12. Employee's Occupation Description:** HUMAN RESOURCES SPECIALIST (EMPLOYEE BENEFITS)
- 13. Cause of injury (Describe what happened and why):** Empty text field.
- 14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg):** Empty text field.

Bottom Screenshot (Filled Form):

- 9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine):** 2ND FLOOR, PERSONNEL READINESS CENTER, 52ND ST MCDOWELL
- 10. Date & time injury occurred MM-DD-YYYY HH:MM [AM/PM]:** 12-10-2013 09:00 AM
- 11. Date of this notice MM-DD-YYYY:** 12-10-2013
- 12. Employee's Occupation Description:** HUMAN RESOURCES SPECIALIST (EMPLOYEE BENEFITS)
- 13. Cause of injury (Describe what happened and why):** WHILE WALKING UP THE STEPS TO THE HUMAN RESOURCES OFFICE, I MISSED THE SECOND TO LAST STEP FROM THE TOP AND FELL LANDING HARD ON MY RIGHT KNEE WHICH HIT THE EDGE OF THE TOP STEP.
- 14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg):** BRUISING AND SWELLING (CONTUSION) TO RIGHT KNEE.

Employee Signature Tab

NOTE 1: If the employee is using Sick and/or Annual Leave during the 45 calendar days from the date of injury for any appointments related to the claimed injury counts against the COP 45 calendar days if the claim is filed within 30 days of the date of injury.

NOTE 2: Regardless of the use of COP, Sick and/or Annual leave, the leave code LU must be input for the date of injury on labor card or time and attendance.

The screenshot shows a web-based form titled "EDI_CA1" with a tabbed interface. The "Emp. Signature" tab is selected. The form contains a certification statement, a list of options for leave type (a, b, c), an authorization statement, a signature line, a date field, a disclaimer, and a supervisor instruction. At the bottom, there are four buttons: "View Claim", "Submit Claim", "Cancel", and "Exit".

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

☐ c. Unknown

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Powered by Diucs

View Claim Submit Claim Cancel Exit

Witness Tab

If there is a witness, have them utilize this tab to input what they saw, heard or know about the claimed injury.

If there was not a witness to the injury, leave all fields blank.

If there are multiple witnesses to the injury, please contact the ICPA for assistance.

EDI_CA1

Emp. Data

Injury

Emp. Signature

Witness

Sup Rpt 1

Sup Rpt 2

Sup Rpt 3

Sup Rpt 4

Safety Data

Sup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Last Name

First Name

Middle Name

Name of Witness: ,

MM-DD-YYYY

Signature of witness: Date signed:

Street Address:

City:

State: ZIP Code:

Powered by Diucs

View Claim

Submit Claim

Cancel

Exit

Supervisor's Report 1

Once the employee information and witness statement have been entered, you as the supervisor, then completes the supervisor's portion of the form.

Block 17 Agency name and address of reporting office: This should always be the following:

AZNG HRO
5636 East McDowell Rd Bldg 5710
Phoenix, AZ 85008

Block 18 Employee's duty station: This should be the work location the employee is assigned (i.e. address for AASF#1 or 2, 161st ARW or 162nd FW, etc.).

Block 23 Date notice received MM-DD-YYYY: This date should be the same as the date the employee and you the supervisor signed the paper CA-1.

The image displays two screenshots of the EDI_CA1 Supervisor's Report form. The top screenshot shows the form with empty fields for agency and employee information. The bottom screenshot shows the form with data entered for AZNG HRO.

Block 17 Agency name and address of reporting office:

- Agency name: AZNG HRO
- Street Address: 5636 EAST MCDOWELL RD BLGD 5710
- City: PHOENIX
- State: AZ
- ZIP Code: 85008

Block 18 Employee's duty station:

- Street Address: PRC 1335 N 52ND STREET
- City: PHOENIX
- State: AZ
- ZIP Code: 85008

Block 19 Employee's retirement coverage:

- ☐ CSRS
- ☒ FERS
- ☐ OTHER (identify)

Block 20 Regular work hours:

- From: 06:00 AM
- To: 03:30 PM

Block 21 Regular work schedule:

- ☐ Sun.
- ☒ Mon.
- ☒ Tues.
- ☒ Wed.
- ☒ Thurs.
- ☒ Fri.
- ☐ Sat.

Block 22 Date of injury: 12-10-2013

Block 23 Date notice received: 12-10-2013

Block 24 Date & time employee stopped work:

Powered by Diluc

Buttons: View Claim, Submit Claim, Cancel, Exit

Supervisor's Report 2

The Supervisor Report sections of the claim form are used to convey facts to the Claims Examiner (Member of the Department of Labor District Office) regarding the claim.

This is crucial especially if the agency is questioning or challenging the claim.

Block 25 Date pay stopped MM-DD-YYYY: Enter the date the employee's pay stopped not to include the date of injury.

Block 26 Date 45 day period began MM-DD-YYYY: If the employee began losing time away from work after the date of injury (DOI) enter the date here.

Block 27 Date & time employee returned to work: Enter if there was a date input in Block 24 if the employee was instructed by treating physician not to return to work due to the injury.

The screenshot shows a web-based form titled "EDI_CA1" with a navigation bar at the top containing tabs: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2 (selected), Sup Rpt 3, Sup Rpt 4, Safety Data, and Sup Signature. The form is divided into several sections:

- Block 25:** "Date pay stopped MM-DD-YYYY" with a yellow input field.
- Block 26:** "Date 45 day period began MM-DD-YYYY" with a yellow input field.
- Block 27:** "Date & time employee returned to work MM-DD-YYYY HH:MM [AM|PM]" with a yellow input field.
- Block 28:** "Was employee injured in performance of duty?" with radio buttons for "Yes" (selected) and "No (If 'No', explain)". Below is a large yellow text area for explanation.
- Block 29:** "Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?" with radio buttons for "Yes (If 'Yes', explain)" and "No" (selected). Below is a large yellow text area for explanation.

At the bottom, it says "Powered by Diucs" and has four buttons: "View Claim", "Submit Claim", "Cancel", and "Exit".

Supervisor's Report 2 Cont.

Block 28 Was employee injured in performance of duty? If you believe that the employee was not injured in the **Performance of Duty**, select **No** and enter the pertinent information into this block and contact the ICPA.

Block 29 Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? If you believe that the employee willfully sought to injury or cause injury to another, performing task while noticeable intoxicated or intentionally doing the tasking incorrectly, select **No** and enter the pertinent information into this block and contact the ICPA.

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 **Sup Rpt 2** Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

25. Date pay stopped
MM-DD-YYYY
[Redacted]

26. Date 45 day period began
MM-DD-YYYY
[Redacted]

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]
[Redacted]

28. Was employee injured in performance of duty?
☒ Yes ☐ No (If "No", explain)
[Redacted]

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?
☐ Yes (If "Yes", explain) ☒ No
[Redacted]

Powered by Diucs

View Claim Submit Claim Cancel Exit

Supervisor's Report 3

Blocks 30 and 31 If there was a third party (manufacture product malfunction, non-DoD civilian, i.e.) that caused the accident that lead to the injury.

For example: If the employee was traveling in a auto vehicle to another work site and was in a car accident with a member of the public, this would be considered a third party caused injury.

Blocks 32 through 34 If the injured employee has gone to their primary care provider, an ER, or Urgent Care facility for medical attention the day of or before entering of the CA-1.

NOTE: If the employee later seeks medical attention after the claim has been submitted, provide the documentation and information to the ICPA.

The screenshot shows a web-based form titled "EDI_CA1" with a navigation bar containing tabs: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2, Sup Rpt 3 (selected), Sup Rpt 4, Safety Data, and Sup Signature. The form is divided into several sections for data entry:

- Block 30:** "Was injury caused by third party?" with radio buttons for "Yes" and "No".
- Block 31:** "Name and address of third party (include city, state, and ZIP code)". Fields include "3rd party name:", "name continued:", "Street Address:", "City:", "State:", and "ZIP Code:". All input fields are highlighted in yellow.
- Block 32:** "Name and address of physician first providing medical care (Include city, state, and ZIP code)". Fields include "Last Name", "First Name", "Middle Name", "Title", "Street Address:", "City:", "State:", and "ZIP Code:". All input fields are highlighted in yellow.
- Block 33:** "First date medical care received" with a date field labeled "MM-DD-YYYY" (highlighted in yellow).
- Block 33a:** "Provided by Agency medical facility?" with radio buttons for "Yes" and "No".
- Block 34:** "Do medical records show employee is disabled for work?" with radio buttons for "Yes", "No", and "Unknown".

At the bottom of the form, it says "Powered by Diucs". There are four buttons: "View Claim", "Submit Claim", "Cancel", and "Exit".

Supervisor's Report 4

Block 35 If you believe that that the statements provided by the employee and/or witness relay what really occurred to cause the injury, change the option to **"No"**, contact the ICPA to review the 5 criteria that every claim must meet to be compensable.

Block 36 If you believe the employee is not eligible to receive Continuation of Pay (COP), please contact the ICPA for a review of the nine reasons the claimant would not be eligible for COP.

Block 37 Please leave this area blank.

The screenshot shows a software window titled "EDI_CA1" with a menu bar containing: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2, Sup Rpt 3, Sup Rpt 4 (highlighted), Safety Data, and Sup Signature. The main content area is divided into three sections:

- Block 35:** "Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?" with radio buttons for "Yes" (selected) and "No (If 'No', explain)". Below is a large yellow rectangular text area.
- Block 36:** "If the employing agency controverts continuation of pay, state the reason in detail." with radio buttons for "Yes (If 'Yes', explain)" and "No" (selected). Below is a large yellow rectangular text area.
- Block 37:** "Pay rate when employee stopped work" with a form containing "Amount:" followed by a yellow rectangular input field, and "Per:" followed by a dropdown menu showing "<not entered>".

At the bottom, it says "Powered by Diucs" and has four buttons: "View Claim", "Submit Claim", "Cancel", and "Exit".

Safety Data

This tab is what will later generate some of the information found on the OSHA 301.

Please mark all that apply to this claim as it is being filed.

Unlike the previous tabs, the White blocks do not have to be marked for you to proceed to the next tab.

The screenshot shows a web-based form titled "EDI_CA1" with a tabbed interface. The "Safety Data" tab is selected. The form contains several sections for recording injury information.

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

Work Environment Exceptions

- ☐ Employee was member of general public rather than an employee at the time of injury.
- ☐ Injury resulted from non-work related event or exposure occurring outside of the work environment.
- ☐ Injury resulted from voluntary participation in a wellness program or in a medical, fitness, or recreational activity.
- ☐ Injury resulted from employee eating, drinking, or preparing food or drink for personal consumption.
- ☐ Injury resulted from personal grooming, self medication, or was intentionally self-inflicted.
- ☐ Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
- ☐ Injury is the common cold or flu.

Privacy Case Status:

General Recording Criteria

- ☐ Employee is deceased as a result of the incident.
- ☐ Employee suffered days away from work as a result of the incident.
- ☐ Employee's work activity was restricted as a result of the incident.
- ☐ Employee was treated in an emergency room as a result of the incident.
- ☐ Employee was hospitalized overnight as an in-patient.
- ☐ Employee lost consciousness as a result of the incident.
- ☐ Employee was transferred to another job as a result of the incident.

Preliminary OSHA Recordability

29 CFR 1904:

OSHA 300 Log Coding:

As Of:

Injury Classification:

Powered by Diucs

Supervisor's Signature

Blocks 38

If there is any information regarding the claim that was not provided in the other areas of the claim, you can use this area to provide it space provided.

For example: If the employee is on a alternate work schedule (5/4/9s), you can indicated what the day off is for the employee. (See next slide)

NOTE: Due to the issues with the email system servers, please input the employees work email and personnel email address into this area. It will be deleted prior to being submitted to DOL.

"Was an on-site investigation conducted?" should always be **"Yes"**! If you asked when, where, what, who, why and/or how, you have conducted an investigation in regards to filing this claim.

With the **"Yes"** the **"What was the root cause of this injury?"**, must be addressed.

The screenshot shows a web-based form titled "EDI_CA1" with a navigation bar at the top containing tabs: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2, Sup Rpt 3, Sup Rpt 4, Safety Data, and Sup Signature. The "Sup Signature" tab is active.

Section 38: A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL MAIL.MIL, ASHLEY.GMAIL.COM, ASHLEY.OUTLAND.YAHOO.COM, OR ASHLEY.OUTLAND.HOTMAIL.COM; EMPLOYEE WORKS AN ALTERNATE WORK SCHEDULE WITH EVERY OTHER MONDAY OFF (IF NOT 5/8'S OR 4/10S).

Was an on-site investigation conducted?
☒ Yes ☐ No

What was the root cause of this injury?
LACK OF SITUATIONAL AWARENESS

If the injury/illness occurred or resulted from duty in a foreign country please select the location: [Empty field]
Additional War Zone Information: [Empty field]

Name of Supervisor: Last Name: WILSON, First Name: SUSAN, Middle Name: E

Signature of supervisor: _____ Date signed: 02-11-2014

Supervisor's Title: SUPR HR SPEC/ HRO Supervisor's Email Address: susan.e.wilson1.civ@mail.mil Supervisor's Office phone number: 6026294834

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

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Buttons: View Claim, Submit Claim, Cancel, Exit

Supervisor's Signature Cont.

This is how the “Supervisor’s Signature” tab should or could look.

NOTE 1: The date for your signature should be the same as the date in which the employee is signing the document as well.

NOTE 2: In the “Supervisor’s Title” area, if you can abbreviate your title to make room to indicate what the main work section you fall under, i.e. HRO, G-1, AASF1, AMXS, MXS, or MOF.

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL@MAIL.MIL, ASHLEY@GMAIL.COM, ASHLEYOUTLAND@YAHOO.COM, OR ASHLEY.OUTLAND@HOTMAIL.COM

Was an on-site investigation conducted?
☒ Yes ☐ No

What was the root cause of this injury? LACK OF SITUATIONAL AWARENESS

If the injury/illness occurred or resulted from duty in a foreign country please select the location: Additional War Zone Information

Last Name First Name Middle Name
Name of Supervisor: WILSON SUSAN E

Signature of supervisor: _____ Date signed: 02-11-2014

Supervisor's Title Supervisor's Email Address: Supervisor's Office phone number
SUPR HR SPEC/ HRO susan.e.wilson1.civ@mail.mil 6026294834

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

☒ No lost time, medical expenses incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

Powered by Diucs

View Claim Submit Claim Cancel Exit

Supervisor's Signature Cont.

Please make sure to input your email address and validate it prior to submitting the claim.

If the information is not input when received by the ICPA, it will be entered based what is in the email Global address book on Outlook.

This is the email that the ICPA will use to correspond with you to request information or provide information to you.

The screenshot shows a web-based form titled "EDI_CA1" with multiple tabs: Emp. Data, Injury, Emp. Signature, Witness, Sup Rpt 1, Sup Rpt 2, Sup Rpt 3, Sup Rpt 4, Safety Data, and Sup Signature. The "Sup Signature" tab is active.

Section 38: A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL@MAIL.MIL, ASHLEY@GMAIL.COM, ASHLEYOUTLAND@YAHOO.COM, OR ASHLEY.OUTLAND@HOTMAIL.COM

Was an on-site investigation conducted? ☒ Yes ☐ No

What was the root cause of this injury? LACK OF SITUATIONAL AWARENESS

If the injury/illness occurred or resulted from duty in a foreign country please select the location: [Redacted]

Additional War Zone Information: [Redacted]

Name of Supervisor: Last Name: WILSON First Name: SUSAN Middle Name: E

Signature of supervisor: [Redacted]

Supervisor's Title: SUPR HR SPEC/ HRO Supervisor's Email Address: susan.e.wilson1.civ@mail.mil Date signed: 02-11-2014

Supervisor's Office phone number: [Redacted]

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in emp
- ☐ No lost time, medical expenses incurred or expected: forwa
- ☐ Lost time covered by leave, LWOP, or COP: forward this fo
- ☐ First Aid Injury

Powered by Diucs

Buttons: View Claim, Submit Claim, Cancel, Exit

Email Validation dialog box:

Please re-type your email address here, before you can continue, then press OK.

OK

Supervisor's Signature Cont.

Block 39: The Filing Instructions

This will tell the system to send this claim directly to the Department of Labor for a claim number or to hold the claim for the injury was not as serious as to warrant a visit to the doctor or just the use of standard First Aid.

If the employee has not gone to the doctor and went right back to work, then select **"No lost time and no medical expense..."**

If the employee went to the doctor on the date of injury (DOI) and return to work the same day, then select **"No lost time, medical expenses ..."**

If the employee went to the doctor on the DOI and was prescribed not to return or decided not return (which in that case would be utilizing sick leave [**LS**] not COP [**LT**] regardless of eligibility), then select **"Lost time covered by ..."**

If the employee is used First Aid measures for the injury, i.e. band-aid, then select **"First Aid Injury"**.

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL MAIL.MIL, ASHLEY.GMAIL.COM, ASHLEY.OUTLAND.YAHOO.COM, OR ASHLEY.OUTLAND.HOTMAIL.COM; EMPLOYEE WORKS AN ALTERNATE WORK SCHEDULE WITH EVERY OTHER MONDAY OFF (IF NOT 5/8'S OR 4/10'S).

Was an on-site investigation conducted?
☒ Yes ☐ No

What was the root cause of this injury?
LACK OF SITUATIONAL AWARENESS

If the injury/illness occurred or resulted from duty in a foreign country please select the location: Additional War Zone Information

Name of Supervisor: Last Name First Name Middle Name
WILSON SUSAN E

Signature of supervisor: Date signed: 02-11-2014
Supervisor's Title Supervisor's Email Address: Supervisor's Office phone number
SUPR HR SPEC/ HRO susan.e.wilson1.civ@mail.mil 6026294834

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

☒ No lost time, medical expenses incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

Powered by Diucs

View Claim Submit Claim Cancel Exit

Supervisor's Signature Cont.

When you are done inputting the information in the required areas, click on the **"Submit Claim"** button at the bottom of the tab.

The dialog box that is displayed should open. Please select the **"View Draft Copy of Claim to Verify Date"**. This will open the *.pdf version of the CA-1 for review, print and signatures (employee, witness and supervisor) and send the 1st two pages of the document.

The screenshot displays the 'EDI_CA1' form with the 'Sup Signature' tab selected. The form contains the following fields and text:

- 38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:**
- EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL MAIL.MIL, ASHLEY GMAIL.COM, ASHLEYOUTLAND YAHOO.COM, OR ASHLEY.OUTLAND HOTMAIL.COM; EMPLOYEE WORKS AN ALTERNATE WORK SCHEDULE WITH EVERY OTHER MONDAY OFF (IF NOT 5/8'S OR 4/10S).**
- Was an on-site investigation conducted?** (Radio buttons for Yes and No)
- What was the root cause of this injury?** (Text field: LACK OF SITUATIONAL AWARENESS)
- If the injury/illness occurred or resulted from duty in a foreign country please select the location:** (Text field)
- Additional War Zone Information** (Text field)
- Name of Supervisor:** (Last Name: WILSON, First Name: SUSAN, Middle Name: E)
- Signature of supervisor:** (Text field)
- Supervisor's Title:** (Text field)
- Supervisor's Email Address:** (Text field)
- Date signed:** 02-11-2014
- Supervisor's Office phone number:** 6026294834

A **Required Submission** dialog box is overlaid on the form, asking "What would you like to do?" with two options:

- View Claim for Printing and Submit to ICPA
- View Draft Copy of Claim to Verify Data (highlighted with a red border)

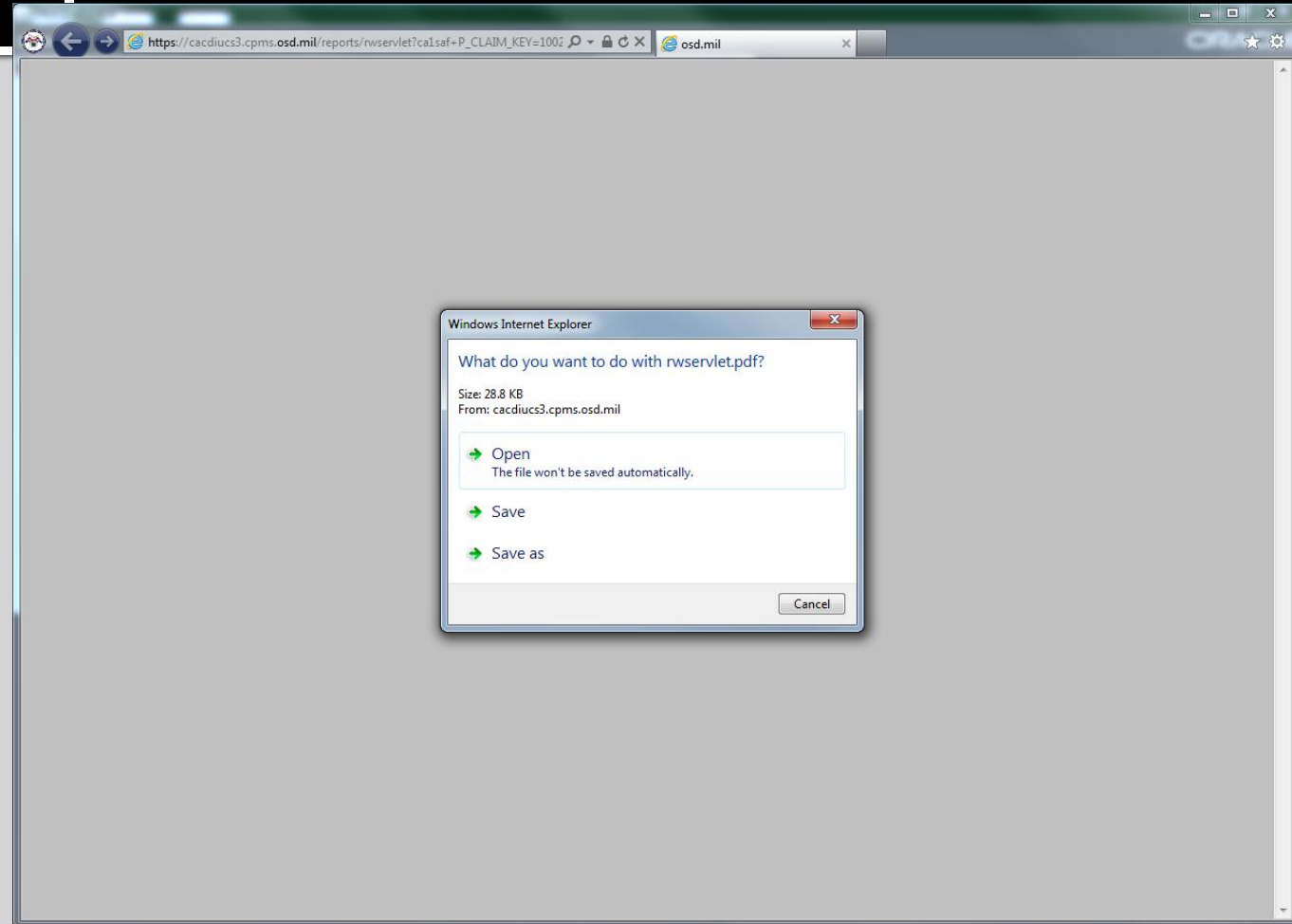
At the bottom of the form, there are buttons for **VIEW CLAIM**, **Submit Claim**, **Cancel**, and **Exit**.

Adobe Reader Web form

When you hit the **“View Draft Copy of Claim to Verify Date”** button, a new window will then open to prompt you to **Open, Save, or Save As**.

To view and print the file for signatures, please select **Open** to see the completed CA-1 form.

If there are any corrections needed to be made you can go back to the online application to make the corrections. If not possible to make corrections or additions at this time, contact the ICPA or ICPA Back-ups with the corrections.



CA-1 PDF File

Please have the employee review to make sure that their information, i.e. address and phone, are correct because that will be the methods in which DOL will use to contact and correspond with the employee.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation			U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs	
Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.			ED I Tracking Number	
Witness: Complete bottom section 16.			100261443	
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.				
Employee Data				
1. Name of Employee (Last, First Middle Suffix)			2. Social Security Number	
OUTLAND ASHLEY C			327844988	
3. Date of Birth	4. Sex	5. Home Telephone	6. Grade as of date of injury	
04/30/1984	FEMALE	5555555555	Level GS09 Step 04	
7. Employee's home mailing address(include city,state, and ZIP code)			8. Dependents	
123 MAIN ST			<input type="checkbox"/> Wife,Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	
TEMPE AZ 85283				
Description of Injury				
9. Place where injury occurred(e.g. 2nd floor, Main Post Office Bldg.,12th & Pine)				
2ND FL, PRC, 52ND ST MCDOWELL RD PHOENIX, AZ				
10. Date injury occurred	11. Date of this notice	12. Employee's job title		
02/11/2014 09:00 AM	02/11/2014	HUMAN RESOURCES SPECIALIST (EMPLOYEE BENEFITS)		
13. Cause of injury(Describe what happened and why)				
WHILE WALKING UP THE STEPS TO THE HUMAN RESOURCES OFFICE, I MISSED THE SECOND TO LAST STEP FROM THE TOP AND FELL LANDING HARD ON MY RIGHT KNEE AGAINST THE EDGE OF THE STEP.				
14. Nature of injury (Identify both the injury and the part of the body, e.g. fracture of left leg)				
BRUSING AND SWELLING (CONTUSION) TO RIGHT KNEE				
			a. Occupation Code 0201 b. Type Code c. Source Code OWCP Use - NOI Code	
Employee Signature				
15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misbehavior, intent to injure, or negligence, or by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work.				

On **Page 4**, you will find an area that indicated that the employee has acknowledged that they have received a copy of the CA-1 .

There is a place for your signature.

Please sign this area as well and prior to sending the ICPA the original signed copies of the 1st two pages, please make a copy of the entire 8 page document and provide it to the employee.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax

identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of injury sustained by
(Name of injured employee)

ASHLEY C OUTLAND

Which occurred on (Mo., Day, Yr.)
02/11/2014

At (Location)
2ND FL, PRC, 52ND ST McDOWELL RD
PHOENIX, AZ

Signature of Official Superior

Title
SUPR HR SPEC/ HRO

Date (Mo., Day, Yr.)
02/11/2014

Form CA-1 Rev.Apr. 1999

Supervisor's Signature Cont.

Once the CA-1 *.pdf file has been reviewed and printed, make sure to go back to the EDI claim window and click the **"Submit Claim"** for the electronic CA-1 to be forward to the ICPA.

REMEMBER: forward the signed CA-1 to the ICPA and provide a copy of the CA-1 to employee for their record of the claim filed.

The screenshot displays the 'EDI_CA1' form window with a tabbed interface. The 'Sup Signature' tab is active. The form contains the following fields and sections:

- Supervisor's Signature Section:**
 - Text: "38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:"
 - Text box: EMPLOYEES EMAIL IS ASHLEY.C.OUTLAND.MIL MAIL.MIL, ASHLEY.GMAIL.COM, ASHLEY.OUTLAND.YAHOO.COM, OR ASHLEY.OUTLAND.HOTMAIL.COM; EMPLOYEE WORKS AN ALTERNATE WORK SCHEDULE WITH EVERY OTHER MONDAY OFF (IF NOT 5/8'S OR 4/10S).
 - Radio buttons: "Was an on-site investigation conducted?" with "Yes" (selected) and "No" options.
 - Text box: "What was the root cause of this injury?" with the value "LACK OF SITUATIONAL AWARENESS".
 - Text box: "If the injury/illness occurred or resulted from duty in a foreign country please select the location:" with a yellowed-out value.
 - Text box: "Additional War Zone Information" with a greyed-out value.
 - Text fields: "Name of Supervisor:" with "WILSON" (Last Name), "SUSAN" (First Name), and "E" (Middle Name).
 - Text field: "Date signed:" with "02-11-2014".
 - Text field: "Supervisor's Title:" with "SUPR HR SPEC/ HRO".
 - Text field: "Supervisor's Email Address:" with "susan.e.wilson1.civ@mail.mil".
 - Text field: "Supervisor's Office phone number" with "6026294834".
- 39. Filing Instructions:**
 - ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
 - ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
 - ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 - ☐ First Aid Injury
- Footer:** "Powered by Diucs" and four buttons: "View Claim", "Submit Claim", "Cancel", and "Exit".

Contact Information

Injury Compensation Program Administrator (ICPA)

SSgt Ashley Outland

Com: 602-629-4818 DSN: 853-4818

Email: ashley.c.outland.mil@mail.mil

Injury Compensation Program Administrator (ICPA) Back-Ups

Mrs. Susan E. Wilson

Com: 602-629-4834 DSN: 853-4834

Email: susan.e.wilson1.civ@mail.mil

TSgt Stacey Mitchell

Com: 602-629-4806 DSN: 853-4806

Email: stacey.a.mitchell6.mil@mail.mil

National Guard Bureau Office of Workers' Compensation Program Liaison

Mr. Russell Groves

Com: 720-250-1177

Email: russell.e.groves2.civ@mail.mil